



CT Behavioral Health Partnership /Charter Oak Behavioral Health Provider Registration System Security Access Form

*** Required Fields**

General Provider Agency Information

*Date _____ *EDS/CMAP ID Number (See Instructions Sheet for Additional Information) _____

*Provider Agency Name _____

*Primary Mailing Address _____

*City _____ *State _____ *Zip _____

*Primary Phone Number (____) _____ *Primary Fax Number (____) _____

*Email Address _____

*USER INFORMATION

(Print or Type)

*Full Name:	*Job Title:
Phone Number:	Address (city,state,zip):
Fax Number:	
Email Address:	*User Role: <i>Please place a check mark next to your user defined role</i> Web Registration Provider Inpatient Bed Tracking Provider

*ACCESS TYPE

(Check One Box)

<input type="checkbox"/> New User Access	<input type="checkbox"/> Change User Access	<input type="checkbox"/> Disable User Access	<input type="checkbox"/> Existing User Access
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Note: This form may only be signed by a supervising authority.

If you need additional assistance please contact the Provider Relations Department @ 1-877-552-8247 or email us @ ctbhp@valueoptions.com

*Authorized Requestor Name _____

*Authorized Requestor Signature _____

TO BE COMPLETED BY VO STAFF

(VO Staff Use Only)

Registration System User ID:	Provider Contract ID:
Additional Comments:	Technical Support Representative Signoff:

Please fax the completed form to 1-(860) 263-2036, Attn: Provider Relations.



CT BHP / Charter Oak Behavioral Health Provider Security Access Form Instruction Sheet

The Charter Oak Behavioral Health Web-Enabled Registration Security Access Form is used to grant Charter Oak providers access to the web-based consumer registration system. The form is broken up into four key sections:

- General Provider Agency Information
- User Information
- Access Type
- VO Staff Section

Your user profile will be created based on information you provide in the first three sections. All required fields must be accurately completed. Required fields are indicated by an asterisk (*) symbol.

The first section, *General Provider Information*, tells us about your primary location. Listed below are the fields and descriptions for this section of the form.

- Date – Enter the date the form is completed and faxed.
- EDS/CMAP ID Number – This is the 9-digit CT Medical Assistance provider number provided to you and/or your organization by EDS. *Please complete this form for the primary EDS/CMAP ID assigned. It is not necessary to complete this form for every EDS/CMAP ID assigned. Please note: Group Practices should enter the EDS/CMAP ID # assigned to the Group Practice, **not** that of the individual group practitioners.*
- Provider/Agency Name – Enter your provider or agency name.
- Primary Mailing Address – Enter the primary mailing address for your practice/agency.
- City, State, and Zip Code – Fill out these fields for your primary mailing address.
- Phone and Fax Number – Enter the main phone and fax numbers for your agency.

The second section, *User Information*, identifies key elements used in identifying the employee using the registration system. This form must be completed for each staff member that will access the system. Listed below are the fields and descriptions for this section.

- Full Name – Enter the full name of the person that this ID is being generated for.
- Job Title – Enter the user's job title.
- Phone Number – Enter the user's office phone number.
- Contact Address – Enter the user's work address.
- Email Address – Enter the user's e-mail address.

The third section, *Access Type*, is used to indicate the purpose of your request. Place an X in the box to the left of the access request type. Listed below are descriptions for each access request type.

- New User Access – Check this box if this is a brand new request.
- Change User Access – Check this box if you have access but need to change some information such as name, phone number, address, etc.
- Disabled User Access – Check this box to if you no longer want or need system access.

The Registration System Security Access form must be signed and the signer's name printed above the signature. The last section will be filled out by Charter Oak staff only. Please fax the completed form to 1-(860) 263-2036, Attn: Provider Relations. You will be notified when your request has been processed. If you have questions regarding the form or registration process, please contact Provider Relations @ 1-877-552-8247.

Please fax the completed form to 1-(860) 263-2036, Attn: Provider Relations.